Healthcare Facility Bariatric Supplemental Application

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Legal Entity Name: ____________________

____

Address: ____________________

____

City, State, ZIP: ____________________

1. Is this facility designated as a Center of Excellence in Bariatrics? ☐ Yes ☐ No
2. Types of open bariatric surgeries:
   a. Gastrointestinal procedures ☐
   b. Biliary surgery procedures ☐
   c. Vertical banded gastroplasty ☐
   d. Roux-en-Y gastric bypass ☐
   e. Extensive gastric bypass (Biliopancreatic diversion) ☐
   f. Other: ____________________ ☐
3. Types of Laparoscopic bariatric surgeries:
   a. Lap banded ☐
   b. Lap stapled ☐
   c. Lap Roux-en-Y ☐
   d. Other: ____________________ ☐
4. Is staff credentialed for bariatric procedures? ☐ Yes ☐ No
5. Does the facility require and utilize a multidisciplinary team including surgeon, anesthesiologist, psychiatrist, eating disorder specialist, internist, cardiologist, dietician, exercise physiologist, etc. for each patient? ☐ Yes ☐ No
6. Is the facility properly equipped to accommodate severely obese patients (chairs, beds, scales, lifts, operating room equipment, bariatric instruments, commodes, wheelchairs, radiology and other diagnostic equipment)? ☐ Yes ☐ No
7. Are there established fall and emergency procedures in place? ☐ Yes ☐ No
8. Are there established follow up and call back procedures in place? ☐ Yes ☐ No
9. Is proper patient selection criteria utilized and documented? ☐ Yes ☐ No
10. Is proper informed consent executed and documented? ☐ Yes ☐ No
11. Please provide a contact name and phone number to schedule a risk management survey.

____________________ Contact Name

____________________ Phone

12. Provide marketing/advertising materials (i.e. newspaper and magazines, brochures, emails, website, etc.).

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Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: ______________________________ Title: ______________________________

Signature: ______________________________ Date: ______________________________

Insurance Agent/Broker (if applicable):			
Agent:	______________________________	Phone:	______________________________
Agency:	______________________________	Fax:	______________________________
Address:	______________________________	Email:	______________________________
	______________________________	License No.:	______________________________
Signature:	______________________________		

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Treated Fairly

Important Notice About the Policy of Insurance for Which You Have Applied

This Document Affects Your Legal Rights

Read the Following Information Carefully

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

Applicant's Signature	Date	Time

Agent	Date	Time

Note: You will need to sign this notice to be considered for coverage.